“If someone offers you an amazing opportunity but you are not sure you can do it, say YES, then learn how to do it later.”—Sir Richard Branson

Presented with inevitable change and opportunity, how will each of our anesthesia groups create its own future? Will you continue to commit yourself to fading traditional practice patterns and payment models? Or will you take advantage of the paradigm shifts that are already upon us?

Payers are demanding better results. The Centers for Medicare and Medicaid Services (CMS) is willing to pay. Our hospitals are begging for physician leadership and our surgeons will need anesthesiologists more than ever. Best of all, proactive physicians in the American Society of Anesthesiologists (ASA) are pointing the way. There is every reason for a great future...depending on how you respond to the challenges.

CMS has been encouraging coordinated care and quality through the Physician Quality Reporting System and the Value-Based Payment Modifier. Those programs, along with the Meaningful Use (EHR) incentive program, will be replaced on January 1, 2019 by the Merit-Based Incentive Payment System (MIPS) and

Continued on page 8
OWNING OUR FUTURE

Deciding on new models for an anesthesiology practice is one of our very biggest challenges. It is not realistic for anesthesiologists to continue believing that if they consistently provide good quality care, all of their financial and business issues will take care of themselves. “The beliefs and strategies that have gotten us to where we are today will not get us to where we want to be tomorrow,” as ABC Vice President Jody Locke writes in his article The Road Not Taken in this issue of The Communiqué.

The transition to value-based payment, combined with the strong trend toward larger anesthesia groups and tight affiliations with national anesthesia companies and/or with health systems, has changed the landscape for traditional independent practices. Bill Britton sums up the current environment in Critical Issues to Consider When Exploring the Sale of Your Practice: hospitals are facing mounting pressures to minimize operating costs, including the costs of subsidizing anesthesia groups; coordinated care is pressuring margins, and uncoordinated quality reporting mandates are increasing operating costs for all.

Mr. Britton, who runs a private equity firm he co-founded, believes that it will become more and more difficult for anesthesia groups to remain independent and that every such group “should begin discussing preparation initiatives that will streamline operations, reduce costs, improve financial transparency, and other specific measures to increase their overall enterprise value.” It may be tempting to consider employment by the hospital or a bigger group, but this option does not realize the equity value of the practice. He urges group leaders instead to consult with the “right M&A advisor” to steer them through the six- to twelve-month process of negotiating a one-time sale to a strategic partner.

A very different option comes from Rick Bushnell, MD, MBA who is working with his hospital in Pasadena, CA to put in place a perioperative surgical home (PSH). Anesthesiology group that, like Dr. Bushnell’s, offers its hospital partner a solid PSH may secure its place with that institution at least for the medium term while CMS rolls out the Merit-Based Incentive Payment System and other pay-for-value programs. In the third of his series of articles on the experience, The Perioperative Surgical Home: Of Economics and Value, Dr. Bushnell lays out the calculations for revenue streams that will help to support the PSH taking shape at his facility.

There are some difficult decisions to be made. Mr. Locke’s article is a plea to groups to be very sure whether to sell or merge or whether to fix one’s own practice, through a PSH or any other strategy that truly enhances the value of the practice.

Will Latham, MBA, CPA explains in detail how to improve an anesthesiology group’s board meetings and decision-making in his article Strengthening Your Board. This manual could not be more timely as the pace of change continues accelerating. As evidence of that pace, Computer-Assisted Personalized Sedation—The Beginning of the End of the Anesthesia Provider? by Steven Boggs, MD, MBA was written just before Ethicon ended sales of the Sedasys® system. Dr. Boggs used the opportunity to remind us all that anesthesia providers are going to remain indispensable for the foreseeable future. What technology could replace their combination of “deep technical expertise, human flexibility, problem solving [skills], creativity and compassion?” Once again, we salute the professions of anesthesiology and nurse anesthesia.

With best wishes,

Tony Mira
President and CEO
Effective anesthesiology group governance is no longer a luxury but instead an important survival skill. Why?

- The external environment is threatening—changes in reimbursement, threats from competitors, hospital consolidation—all add up to the need to make decisions, change and adapt.
- The internal dynamics of many groups are challenging—getting “the entire herd roughly moving west,” dealing with disruptive physicians, developing an agreed upon group strategy—all require a well-organized governance system.

Whether your group’s Board includes all the shareholder physicians, or you have chosen a subset of the shareholders to serve as the Board, there are a number of steps that you can take to strengthen your Board’s performance. Here are several of the most important steps that an anesthesiology group Board can take.

**Improve Board Meetings**

We begin with Board meetings. Why Board meetings?

1. No matter your group’s size, meetings are a tool that all groups use in their governance processes.
2. Much of the work of governance is done in group meetings. Yes, there is often a lot of background work done outside of meetings, but the real discussions, debate and decision making is typically done at group meetings.
3. We have observed that many medical group meetings are chaotic and unproductive. Many physicians do not understand or appreciate the importance of effective meeting management. If meetings don’t work well, practice governance doesn’t work well. The wrong issues are discussed, reasonable conclusions are not reached, decisions are not made.

Now some of you won’t pay attention to these ideas because either “we don’t need to do that” or “we don’t want to do that.” However, keep in mind that “Insanity is doing the same thing and expecting a different result.” The bottom line is that successful governance requires successful meeting processes.

Luckily there are a number of steps that you can take to dramatically improve the effectiveness of your group meetings. Here are two key steps:

**1. Develop and Utilize Ground Rules**

Think about your most recent group meeting. Did the attendees exhibit any of the following behaviors?

- Multiple people talk at the same time.
- The conversation drifts way off topic.
- Interrupting telephone calls are taken in the meeting room.
- Participants arrive late.
- Low physician attendance.
- Some participate in the discussions, while others don’t (until the “after the meeting meeting”).
- Individuals raise many problems but do not pose solutions.
- There are many sidebar discussions—either by talking to the person seated next to them, or through texting.

To help eliminate these behaviors, the Board should develop “Ground Rules” for Board meetings. Ground Rules are the observable behaviors that the group members agree are expected from every attendee. The focus is on observable behaviors.

Let me provide an example of an unobservable behavior. A Ground Rule that states that everyone is expected to “be open-minded” is subject to dispute, depending on an individual’s viewpoint. Why? Because being “open-minded” occurs inside the brain and is not a undisputable observable behavior.

It’s best to set Ground Rules as a group process. In other words, you should have the attendees develop the Ground Rules together rather than copy the list below and say “here are our new Ground Rules.” Individuals are more likely to adhere to the Ground Rules if they have a hand in developing them.

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You should ask the attendees, “what observable behaviors should be expected of each attendee?” Their responses should cover the following key Ground Rules:

1. One person speaks at a time and everyone else listens.
2. Arrive on time.
3. Stay on topic.
4. All are expected to participate in the discussion.
5. Work towards solutions.
6. No sidebar discussions—oral or texting.
7. If you have to take a telephone call, leave the room so work can continue.
8. Everything we discuss is confidential unless we specifically agree otherwise.

The best performing groups quickly review the Ground Rules at the beginning of every meeting. This doesn’t take long and the pay-off is huge. Some groups type the Ground Rules at the top of their meeting agenda, while others post the Ground Rules on a cardboard sign that they bring to each meeting. But that is not enough—you must review it at each meeting. It only takes a few seconds to do, but it strongly influences behavior.

Most groups find that group meeting performance will improve simply by verbalizing the Ground Rules. You will likely also find increased meeting attendance as individuals begin to expect more organized and effective meetings.

But the Ground Rules will become even more effective when they are utilized by the group’s “Meeting Manager.”

2. Establish a “Meeting Manager”

The “Meeting Manager” is the most critical person in regards to how well meetings operate. The Meeting Manager is the person in charge of running the meeting and he or she has the authority to regulate the meeting and is responsible for:

- Enforcing the ground rules.
- Keeping order.
- Ensuring that any discussion is relevant to the points on a meeting’s agenda and preventing irrelevant debate.
- Repeating any motion proposed by those attending to ensure that everyone has heard and understood it.
- The successful completion of business.
- Summing up the discussion at the end of the meeting.

In addition, it often falls to the Meeting Manager to remind the Board members to make their decisions based on what is best for the entire organization as defined in the group’s mission statement, vision, values and strategic plan.

The ideal Meeting Manager should have a wide range of personal skills, such as:

- Firmness in running the meetings on time and dealing with problems.
- Ability to summarize points succinctly.
- Flexibility when dealing with the different tones and styles of attendees.
- Openness and receptiveness when listening to opinions that they do not share.
- Fair-mindedness in ensuring that all views are aired and given equal initial consideration.

The Meeting Manager is often the chairman or president of a group, but does not have to be. For example, several years ago we worked with an anesthesiology group that had a great president. He was excellent in regard to most of the functions required of him. However, he couldn’t manage his group’s meetings. He was unable to keep the discussion on track and moving forward. This group kept him as president and elected another physician to be the Meeting Manager.

3. Use Secret Ballots

Over the years we have come to realize that most physicians (when it comes to interactions with other physicians in their group) are conflict avoiders. They fear being attacked by other members of the group during discussions (the Meeting Manager should prevent this), and they often fear
later retribution when they support or don’t support a particular issue.

Once a decision has been discussed, many groups ask for a vote on which way to proceed (we recommend that groups formally vote on all issues). However, if there is significant disagreement on an issue, some physicians are hesitant to “vote their conscience” by publicly raising their hand. In fact, many group meetings last much longer than they should as people want to put off voting (and thus showing their decision) as long as possible.

Most groups use secret ballots for electing their Board and officers, but some groups use them when they need to vote on controversial issues, or in some cases, all issues.

Why are secret ballots useful?

- They allow the individuals to “vote their conscience” with less fear of retribution.
- They avoid one physician bullying another physician into changing their vote.
- They often speed up a meeting because people don’t delay voting to put off conflict.

There are several ways to implement secret ballots—here are two:

1. Use 3 x 5 cards as the secret ballots.
2. We have observed some groups starting to use audience response systems. One medical group president recently told us that his group has begun using such a voting system for all issues. He said they had cut about 25 percent off the time of every meeting by using the system.

Groups that use secret ballot for all their issues have told us that there is only one potentially negative outcome—that people will push too quickly for a vote. Therefore, it is up to the Meeting Manager to make sure that the group has had a full discussion of the issue prior to voting.

4. Create a “Speed Bump” To Avoid “Re-Visit Torture”

Many medical groups make a decision and then re-visit it over and over again.

This situation comes about when a few members of the group do not get their way in the first vote. They then use this strategy to either torture the group into changing the decision, or to paralyze the group.

When other group members state their frustration about the problems revisiting an issue will cause, the physicians who want to revisit the issue typically respond that additional information has come to light which they believe should be considered in making the decision. This can go on ad infinitum and the ability to pursue key opportunities (or the ability to avoid key threats) can be lost.

Many organizations suffer from this problem, but the situation is more challenging for medical groups where the shareholder physicians are usually equal owners of the practice. Some physician shareholders believe that equal ownership gives them the right to have a say about every issue at any time they want (and often waste precious group meeting time). While it is true that the shareholder physicians are usually equal owners, medical groups have the ability to prevent this perceived right from being used as a torture technique.

One way to reduce the use of this torture technique (revisiting issues over and over again) is to put in a “speed bump” for items to return to the agenda for discussion.
**Strengthening Your Board**

*Continued from page 5*

For example, the group could implement a policy that requires 30 percent of the shareholders to sign a document asking to bring an item back to the floor for re-discussion once a decision has been made (it is important that they sign a document, rather than someone say “I had 30 percent of the people say they’d like to re-discuss this issue”).

This policy doesn’t close the door to re-discussing an issue (if more than 30 percent want to re-discuss an issue, the group probably should). However, it will typically reduce the number of times this torture technique is used.

Medical groups that have a Board of Directors (composed of a subset of the shareholders) face the problem that individual shareholders will want to discuss decisions made by the Board that are clearly within the authority of the Board (I will have a lot to say about authority in later articles).

You can use the speed bump discussed above for Board decisions, but another strategy is to create a policy to overturn a decision of the Board that is within their scope of authority, a super-majority vote of the shareholder will be required. This strengthens your Board and makes the Board members more confident in making decisions that are best for the group.

### Use Committees Effectively

Many anesthesiology groups establish committees to carry some of the load of governance. Unfortunately, they often do not define the role and responsibilities of the committees, and therefore committee performance is sub-optimal.

As a first step, the Board should create a committee charter for each committee. An example of such a charter is found in Exhibit 1.

<table>
<thead>
<tr>
<th>Exhibit 1</th>
<th>Example Committee Charter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committee</strong></td>
<td>Finance</td>
</tr>
</tbody>
</table>

**Responsibility**

- Supervise and develop the annual operating and capital budgets. Recommend periodic revisions to the budget.
- Supervise the financial matters of the group and its subsidiaries.
- Review and monitor the financial performance of the group.
- Advise the Board on all financial aspects of the practice.
- Ensure appropriate filing of all applicable tax returns.
- Ensure evaluation and annual compensation review for all staff members.
- Assist in negotiation of contracts with third parties. Chairman participates on contract negotiation team.
- Conduct periodic review of professional relationships (accountants, attorneys, etc.).

**Authority**

Advisory only.

**Chairperson**

Dr. Jones

**Members**

Dr. Thomas
Dr. Brit
Dr. Peters

**Meeting Frequency**

Monthly

**Compensation**

Budgeted two hours of meeting time each month. Compensated $200 per hour.

**Annual Work Plan**

- Evaluate reduced work program.
- Revise capital budgeting system.
- Develop cost accounting system.
- Analyze supplies expense for reductions.
Once the committee has developed a solution or recommendation, this information should be presented to the Board. However, the Board must be extremely careful to not redo the work of the committee. If the Board feels the committee has not completed the assignment it should be sent back to the committee for further work.

In addition, the Board should make every effort to accept the committee’s recommendation. Why? If the Board always rejects the committees’ recommendations or redo the work, the committees will reach the conclusion that their thoughts are not being considered and stop doing the work.

**Survey Group Members**

Effective communication between the Board and shareholders is critical. There are times the shareholders feel out of the loop or that they have no input into the governance of the group. To keep shareholders in the loop the Board should provide shareholders with Board meeting agendas and minutes and conduct other communication activities.

Over the past couple of years we have noted another communication tool that is being used effectively—on-line surveys. These better performing groups are using online surveys to obtain input from the shareholders prior to deliberating on issues. They are clear that they are not asking the shareholders to vote on the issue, but instead to provide their thoughts on what should be considered as the Board addresses the issue.

**Demand Support of Board Decisions**

There will be times when all Board members do not agree with a Board decision. This is to be expected. The question is: what is expected of a Board member when a decision is not the one they wanted?

In our experience, effective Board members speak in support of Board decisions, even if it is difficult.

Mature Board members understand the difference between supporting a decision and agreeing with it. Board members should be able to support a Board decision if the decision:

- Was voted on after a range of views were explored;
- Is based on the best available knowledge; and
- Is consistent with the group’s stated mission and vision.

The Board should set aside time to discuss how it will handle disagreements. We recommend that all Board members agree to communicate Board decisions as follows:

1. “We thoroughly discussed the issue…”
2. “We considered a number of alternatives…”
3. “The Board agreed that this was the right thing to do…”
4. “I plan to support the decision…”
5. “And you should too.”

**Will Latham, MBA, CPA, President, Latham Consulting Group, Inc.**

Latham Consulting Group helps medical group physicians make decisions, resolve conflict and move forward. For more than 25 years Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; assisted over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Latham has an MBA from the University of North Carolina in Charlotte and is a Certified Public Accountant. He is a frequent speaker at local, state, national and specialty-specific healthcare conferences. Mr. Latham can be reached at (704) 365-8889 or wlatham@lathamconsulting.com.
Alternative Payment Models (APMs). CMS will pay up to a four percent bonus for high self-reported MIPS scores and up to a four percent penalty for poor performers, beginning in 2019. In 2019, therefore—assuming that the overall amount of penalties assessed offset the amount of bonuses, in budget-neutral fashion—the difference between maximum positive and negative scores will be eight percent and by 2022 the difference will be 18 percent—every single year. Might I ask what return on your business investment do you need? When did you achieve that return on your personal investment portfolio? Private payers are sure to soon follow suit, but this 18 percent CMS incentive alone is strong enough that anesthesiologists should fully embrace MIPS quality and coordinated metrics. As for APMs, if you receive a “significant portion” of your Medicare payments through an eligible APM entity, you will be totally exempt from the MIPS requirements. As a “qualifying APM participant,” you will receive a five percent bonus in each of the five years between 2019 and 2024. From 2026 onward, you will be eligible for 0.75 percent increase in your annual Medicare payments—half a percent more than physicians who merely satisfy MIPS.

Our hospital administrative partners, who are subject to their own increasingly important value incentives, are begging for anesthesia’s help. If they haven’t yet realized the value of your perioperative skill set, then it’s time for you to offer to show them. Administrators are overworked, under-inspired and dealing with their own mandates to coordinate care and share outcomes data. Hospitals are also subject to their own system of CMS penalties, caps and bundled payments. You may not personally know it yet, but your management and vision are in demand and needed outside the operating room. Your new management target is the 20 percent of sickest patients presenting for surgery. These are the patients at highest risk for readmission and anesthesiologists need to see those patients in clinic beforehand. This is the time and place for medical leadership.

Fortunately for our specialty, the ASA is pointing the way to the concept of the Perioperative Surgical Home (PSH). For the ASA, this is the moral and medical core of the future of our specialty. Who better than anesthesiologists to understand the physical challenges posed to patient physiology by surgery? Who better to coordinate the preoperative work-up, the acute intraoperative care and the post-discharge medical management? Establishing an Anesthesia PSH clinic is medically and politically valuable to your group.

Then that pesky, repetitive, timeless question arises, “But how do I get paid for being in clinic?” If perioperative management of the sickest patients is such a great thing, who is willing to support that anesthesiologist? Will CMS and private insurance pay; will anesthesia groups internally reimburse and will hospitals share the savings back with anesthesia groups?

Believe it or not, CMS is willing to pay. “Yes,” there are fee-for-service codes. “Yes,” they will pay for both preop and post-discharge management. “Yes,” you can use these codes for your clinic time. And just as you suspected, “No,” it’s not enough. But let’s explore the initial math of fee-for-service clinic appointments.

Consider our southern California hospital, Huntington Memorial (HMH), with 14,562 outpatient and 8,934 inpatient surgeries per year (total 23,496). Because of our PSH proposals, HMH will strongly encourage surgeon triage and risk stratification of these patients. HMH will soon mandate the appearance of all patients in preop clinic before elective surgery and assign the 20 percent of sickest to be seen by an anesthesiologist. Our Pacific Valley Medical Group (PVMG) anesthesia group will station one full time equivalent (FTE) anesthesiologist in clinic targeting the 20 percent of sickest patients, clearing, medically optimizing or canceling them as indicated. The goal is for our anesthesiologists to also see these same 20 percent of sickest patients in post-discharge clinic.

So based on the assumptions below,* let’s do the math on just three of the various revenue streams that could be used to support our private practice, full-time equivalent PSH clinic anesthesiologist.

### The Fee-for-Service Payment Model:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Descriptor</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10 minute appointment, easy medical decision making</td>
<td>$28.76</td>
</tr>
<tr>
<td>99202</td>
<td>20 minute appointment, easy medical decision making</td>
<td>$54.51</td>
</tr>
<tr>
<td>99203</td>
<td>30 minute appointment, low complexity of medical decision making</td>
<td>$83.05</td>
</tr>
</tbody>
</table>

CMS Payment for Pre-Operative Evaluations Current Procedural Terminology (CPT®) Codes for Los Angeles (locality #0118218) in 2016:

- CPT 99201: 10 minute appointment, easy medical decision making
- CPT 99202: 20 minute appointment, easy medical decision making
- CPT 99203: 30 minute appointment, low complexity of medical decision making

* In order to calculate the bonus, you would need to know the total number of in-patients eligible for post-discharge transitional care, the number of Medicare patients at HMH, and the ‘capture rate’ (expected follow-up post-discharge transitional care clinic).
### Post-Discharge Transitional Care Management Reimbursement Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495</td>
<td>'face-to-face' visit, within 14 days of discharge, moderate complexity</td>
<td>$119.49</td>
</tr>
<tr>
<td>99496</td>
<td>'face-to-face' visit, within seven days of discharge, highly complex decisions</td>
<td>$172.89</td>
</tr>
</tbody>
</table>

Average = $146.19

For the purposes of the revenue projection below, we’ll assume an average mix of CPT codes submitted to CMS. Let us also assume Medicare patients constitute 32 percent (actual HMH payer mix) of clinic appointments.

Using the above averages to project Medicare perioperative clinic payment:

**Projected Medicare Income**

$150,277 pre-operative evaluation income from fee-for-service

### Merit-Based Incentive Payment System (MIPS) Savings or Bonus

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings or Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4% penalty to +4% bonus = 8% differential</td>
</tr>
<tr>
<td>2020</td>
<td>-5% penalty to +5% bonus = 10% differential</td>
</tr>
<tr>
<td>2021</td>
<td>-7% penalty to +7% bonus = 14% differential</td>
</tr>
<tr>
<td>2022+</td>
<td>-9% penalty to +9% bonus = 18% differential</td>
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</table>

Anesthesiologists should understand these codes and their associated compliance criteria.

**At-Risk Medicare Payments to Anesthesia Practice, 2019–2022 Onward**

Groups must quantify the contribution of the PSH to their practices. The Medicare MIPS at-risk numbers for our PVMG anesthesiology practice are:

- Merit-Based Incentive Payment System (MIPS) Savings or Bonus

### Costs to Hospital of Preventable Readmissions

Hospitals must quantify the contribution that anesthesiologists can make to hospital cash flow. The Medicare preventable readmissions at-risk numbers for HMH are:

**Projected 1st Year Savings and Potential Incentives to the PSH**

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings or Bonus</th>
</tr>
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<tbody>
<tr>
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Assuming that PVMG qualifies for the maximum MIPS amount in each of the five years 1919–2023:

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</tr>
<tr>
<td>2022+</td>
<td>-9% penalty to +9% bonus = 18% differential</td>
</tr>
</tbody>
</table>

**Projected Total Medicare Income**

$150,277 pre-operative evaluation income from fee-for-service

- $4,700,000 Medicare payment to PVMG (2015 data)
- x 8% at stake in 2019
- $376,000 payment at stake in 2019
- $4,700,000 Medicare payment to PVMG (2015 data)
- x 10% at stake in 2020
- $470,000 reimbursement at stake in 2020
- $4,700,000 Medicare payment to PVMG (2015 data)
- x 18% at stake in 2022
- $846,000 payment at stake in 2022
- $4,700,000 Medicare payment to PVMG (2015 data)

Hospitals must quantify the contribution that anesthesiologists can make to hospital cash flow. The Medicare preventable readmissions at-risk numbers for HMH are:

**Projected 2nd Year Savings and Potential Incentives to PSH**

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings or Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
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**Projected Total Medicare Income**

$150,277 pre-operative evaluation income from fee-for-service

- $4,700,000 Medicare payment to PVMG (2015 data)
The Perioperative Surgical Home: Of Economics and Value

Continued from page 9

<table>
<thead>
<tr>
<th>x 20%</th>
<th>targeted decrease in readmissions, 2nd year of PSH operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>= $704,456</td>
<td>targeted savings from Medicare readmissions</td>
</tr>
<tr>
<td>x 10%</td>
<td>suggested incentive to support the PSH FTE anesthesiologist</td>
</tr>
<tr>
<td>= $70,445</td>
<td>incentive bonus, 2nd year, to support anesthesia in clinic if targets met</td>
</tr>
</tbody>
</table>

Projected 3rd Year Savings and Potential Incentives to PSH

| = $3,522,288 | cost to HMH of Medicare readmissions |
| x 30% | targeted decrease in readmissions, 3rd year of PSH operation |
| = $1,056,686 | targeted savings from Medicare readmissions |
| x 10% | suggested incentive to support the PSH FTE anesthesiologist |
| = $105,668 | incentive bonus, 3rd year, to support anesthesia in clinic if targets met |

The total potential savings to HMH is projected to be $1,056,684 over three years which justifies PSH support for anesthesiologist involvement. This incentive projection peaks around $100,000 in the third year and is used in summary calculations below.

Hospital Savings Accrued through Decreased Length of Stay**:

New York University (NYU) School of Medicine has now demonstrated that patients who attend their preop evaluation clinic have significantly shorter length of stays (LOS) and observed-to-expected LOS ratios than those who do not attend clinic.

For the NYU study’s financial analysis, 28,828 surgical encounters were included. There were 17,593 patients who attended clinic and 11,235 who did not. The mean variable direct cost per case was $5,754 for patients seen in the preoperative clinic and $7,127 for those who were not. The resulting savings were more than $1,373 per case.

Assuming much and applying the NYU numbers to HMH’s Medicare population: Hospitals should be willing to invest and incentivize to support the PSH FTE anesthesiologist in the PSH in an attempt to lower readmission rates and costs.

| 4,699 | preop clinic appointments (from Medicare data above) |
| x $1,373 | savings per case (from NYU data above) |
| = $6,451,727 | savings on Medicare patient length of stay seen in preop clinic |
| x 10% | suggested incentive to support the PSH FTE anesthesiologist |
| = $645,172 | incentive bonus if LOS targets met (negotiated between hospital and anesthesia) |

The Total of Annual At-Risk and Potential Cash Flows Available for Support:

| $217,060 | total fee-for-service from Medicare only (from above) |
| + $319,600 | expected increased Medicare reimbursement to anesthesia group (from above) |
| + $100,000 | incentive bonus from hospital, if readmission targets are met (from above) |
| + $645,172 | incentive bonus if LOS targets met (negotiated between hospital and anesthesia) |
| = $1,281,832 | total potential cash flows to support one PSH FTE preop anesthesiologist |

This is our bottom line result using only a Medicare population (32 percent of inpatient surgeries). Certainly if we included private payer patients, the total potential savings and cash flows would be much larger. Based on these financial calculations, hospitals and practices have all the financial motivation they need to form joint ventures.

Possibly more important, you now have an objective analytic process by which to work your own numbers. By projecting your own practice’s contribution, you can approach your own Accountable Care Organization (ACO) with objective financial cause for an appropriate percentage of future bundled payments. An anesthesiologist presence in the PSH is negotiating power.

My strong suggestion is that hospitals and anesthesia practices contribute to a financial plan that supports one FTE clinic anesthesiologist. The joint hospital/practice financial plan should be monitored closely by all parties and adjusted accordingly. The stated goal of the financial plan should be an effective system of incentives and support, not an excessive revenue stream for the anesthesia practice or physician. Excess funds should be qualified and retained in a separate pool for use as additional personnel or performance incentives.

Your Own Amazing Opportunity

You now have my calculations, projections and suggestions for generating payment support from three categories of PSH cash flows. It may take a bit of financial creativity, but the combination of fee-for-service, shared CMS savings and hospital incentives should be enough to support one FTE anesthesiologist in the PSH. A well-constructed financial plan should get most organizations to that point. But allow us to conclude by considering a calling.

At the beginning of this article, Sir Richard Branson spoke of taking advantage of “an amazing opportunity.” His
reference was to business and finance. Surely those issues are important, but consider what an amazing opportunity the PSH is for medical leadership.

Anesthesia is naturally positioned at the logistical and medical nexus of surgical challenges presented to both the patient and the healthcare system. It is my postulate that this position obligates our specialty to exercise greater medical leadership than we have lately assumed. Thirty years ago patients were admitted for surgery the night before and stayed a week after the procedure. We rounded on our next day’s patients the night before and called on them the day after surgery. Today we meet complicated patients three minutes before surgery and seldom round on them afterward, if they are admitted at all. We’ve allowed ourselves to become anonymous and our reputation often now suffers from invisibility. We are often being replaced by mid-level care providers.

The PSH is the perfect position from which to reclaim the medical authority that has slipped away from anesthesiologists. We can only reassert the great value of our specialty by practicing our medical and management skills thought out the entire continuum of the perioperative surgical process. Stepping up to assume our share of the responsibility for outcomes will naturally give rise to the credibility only medical leadership can confer.

Greater anesthesia involvement promises increased day-of-surgery efficiencies, increased rapport between services, better outcomes, increased patient satisfaction and the elevated perception of our specialty. How could these things not flow from our greater ownership of all the obligations of our position? We already know we can do better than delegating ourselves to three minutes before surgery and one minute after. It is now time to pick up this cause and to once again own all of our obligations. This is the reclamation and maturation of our specialty.

It is my personal challenge that you value the opportunity for medical leadership above all cash flows. Your physician presence in the PSH is your own “amazing opportunity.” As an anesthesiologist, this is the platform upon which to practice your entire medical skill set and to exert your medical leadership.

In the fourth article of this series, which will appear in the summer issue of the Communiqué, let us consider the future of the Perioperative Surgical Home.

*Assumptions and Caveats: Some aspects of CMS programs are beyond the scope of this article. For the cause of simplicity and to focus on the major issues, many details and arguments have been reserved for another conversation. Please accept the assumptions below that we have made for the sake of analysis here.

1. The limitations of data access necessarily confine this analysis to publically available Medicare data. Private data have not been included. More complete individual analysis should include billing company, individual practice and hospital data that is inclusive of private payer reimbursements.

2. The stated, targeted goal is to have our anesthesiologist attend to the 20 percent of sickest patients is an arbitrary number. That number will not be initially achievable for many reasons, principally the challenge of volume. Totaling the projected pre- and post-op clinic appointments and dividing that number into the available days results in the clinic anesthesiologist attending to 23 appointments per day. This number is not feasible and reductions of volume based on actual clinic volume will likewise reduce fee-for-service revenue projections.

3. Not all MIPS or APM scores will or can be improved by the PSH. It is assumed that commitment to the high level of coordinated care it takes to manage a PSH will lead naturally to commitment to all areas of quality scoring and reporting. Credit the PSH with leadership.

4. Conversations concerning MIPS, APMs and Value-Based Purchasing will be taken up in another article.


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Computers and improvements in modern anesthesia delivery have gone hand-in-hand. In 1952 Himmelstein and Scheiner reported that they began using an instrument called the cardiotachoscope and found it useful during surgery. In 1958 Ben Ettelson and James Reeves started Spacelabs to develop systems for the United States Air Force for monitoring vital signs of U.S. astronauts. This technology returned to earth, with the 1970s witnessing the expansion of digital electronics in operating rooms (ORs) and critical care units (CCUs). The 1980s saw clinical penetration of modularity and utilization of saturation and end-tidal carbon dioxide monitoring. As pharmaceuticals developed shorter and shorter clinical half-lives and microprocessor technology continued to improve, the concepts of closed-loop (CL) anesthesia, targeted-controlled infusion (TCI) devices and other computer-controlled delivery systems moved from theoretical possibilities to clinically relevant systems.

In the late 1990s Dr. Randy Hinkle, an anesthesiologist, formulated the initial concept that ultimately became Computer-Assisted Personalized Sedation (CAPS). Ethicon manufactured and distributed the only FDA-approved CAPS system, named Sedasys, until it decided to “pull the system to focus on other opportunities.” It is unclear at present whether another company will take over this technology or if the healthcare facilities in which Sedasys is in use will continue to use it. Nonetheless, the technical, safety and cost implications of systems such as Sedasys are an interesting case study.

The actual specifics of how the system functions are beyond the scope of this article. Company material and peer-reviewed literature describe the operation of the system. Significantly, Sedasys is neither a CL delivery system nor a TCI device. Propofol is delivered via continuous infusion rather than a bolus dose and Sedasys integrates oxygen saturation, exhaled carbon dioxide, non-invasive blood pressure and heart rate (EKG) monitoring. As recommended by the ASA Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, patient responsiveness is also monitored by an Automated Response Monitor (ARM). Studies have shown that patients lose response to the ARM before they transition from Moderate Sedation (MS) into Deep Sedation (DS). Importantly, Sedasys is intended for the administration of mild to moderate sedation (MS) for either a colonoscopy or an esophagogastrroduodenoscopy (EGD) (not both procedures on the same patient).

Ethicon slowly introduced Sedasys into the market. Initially, only two sites used the device. Then the Virginia Mason Medical Center (Seattle, WA), the Grace Clinic (Lubbock, TX), Promedica Toledo Hospital (Toledo, OH) and Loma Linda University Medical Center (Loma Linda, California) adopted the Sedasys system. Other centers were ready to begin using the system prior to the announcement that Ethicon was exiting the market, but the company did not release the names of those centers.

Virginia Mason initially started with two devices, increasing this number gradually to the current number of eight Sedasys units. Both Dr. Andrew Ross, Section Head for Gastroenterology and Dr. Wade Weigel, Section Head of out-of-OR anesthesia at Virginia Mason have indicated that the Sedasys system achieved several objectives for the hospital, for the gastroenterology department and for Virginia Mason patients. It provided efficiency gains within the endoscopy unit. Both patients

1. http://www.referenceforbusiness.com/history/Sh-St/Spacelabs-Medical-Inc.html
and gastroenterologists have been satisfied with the system and there have been no severe airway or cardiorespiratory complications in more than 8,500 cases performed to date.\(^4\)

There are several limitations imposed on the users of Sedasys. As specified in the FDA approval, an anesthesia provider must be immediately available if required should airway management or other patient management issues arise. The unanswered question here is, “How immediately available is immediately available?” This precludes the use of the device in isolated gastroenterology offices and restricts its use to larger centers. Even in these centers, however, it is unclear how anesthesia provider availability will be allocated.\(^5\) Also, there is a limit to the amount of concomitant medications the patient can receive in addition to the propofol infusion.

There is also the issue of revenue and costs. Based on the information from my colleagues at Anesthesia Business Consultants, total anesthesia payment for both EGD or colonoscopy (not both at the same time) procedures from January to June 2015, excluding government payees, was approximately $300.00. When I spoke with Ethicon about their pricing models prior to their decision to pull the system from the market, the comment was, “We have presented a couple of different sedation delivery models to selected regional payers including models that include payment for anesthesia medical direction or anesthesia patient selection and assessment are actively working with two payers to develop pilots that provide reimbursement to those willing to adopt those models. We would like to invite any of the readers to contact us should they be interested in exploring new business models leveraging this technology.”

In current payment systems, the gastroenterologist receives her/his fee and the anesthesia payment is separate from that fee. There are growing financial incentives in the U.S. healthcare system to develop new methods of both payment and procedural sedation that decrease anesthetist involvement in certain cases. Throughout Europe most colonoscopies and EGDs are performed without an anesthesiologist. This is especially the case in Germany and Switzerland and their outcomes are no worse than those seen in the USA.\(^6\) Also, in the United States, from 2003 to 2009 there was a significant expansion of anesthesia involvement in sedation for colonoscopies. This expansion was greatest in patients classified as either ASA I or II, not in patients having multiple comorbidities.\(^7\)

In the past Sedasys could be purchased or leased for approximately $200,000.00. In this case, the per-procedure charge for disposables was lower (approximately $110.00 – $120.00). More recently, one could buy only the disposables on a per-case basis at a slightly higher charge if the machine were not purchased (approximately $150.00 for disposables per procedure). In the former case, at least 2,000 cases per room each year would have to be performed to optimize financial performance.

Constraints on the healthcare budget will only grow in severity. As our healthcare system transitions from a fee-for-service to a value-based payment model, anesthesiologists will have to collaborate with other specialties to reduce total costs. The Rand Corporation conducted a study for the ASA in 2013 and its likely projection is that the supply of anesthesiologists will peak in 2017 and decline thereafter.\(^8\) If you couple this forecast with the explosive growth of NORA procedures, the need for anesthesiologists will not be eliminated. Alternative payment models where reimbursement for the department of anesthesia’s contribution to net hospital revenue and involvement in a unit with Sedasys or other CAPS systems will need to be created.

Meanwhile, data from the CDC demonstrate that our country is not screening all of the patients we should for colorectal cancer. Colorectal cancer remains the second leading cause of cancer death in our country and the annual expenditure for this specific diagnosis was $14 billion dollars in 2012.\(^9\) We do need to expand our screening of patients but we must do so in a cost-effective manner.

One critical issue concerning the use of Sedasys or any other technology for the administration of mild-to-moderate sedation is the framing of patient expectations. Most clinicians in anesthesia are familiar with the dread look one receives when discussing a regional block with an orthopedic patient whose orthopedist has forgotten to mention a nerve block to them. Likewise, with a system such as Sedasys which provides mild-to-moderate sedation, it is critical that the gastroenterologist explain to the patient that they may remember parts of the procedure and experience some discomfort. The patient should not anticipate “having the best sleep of their life” and they should not anticipate being unconscious for the procedure.

\(^4\) Personal communication(s), Drs. Andrew Ross and Wade Wiegel.


\(^6\) World J. Gastrointest Endosc 2015; 7(2):102-109


\(^8\) http://www.anacalifornia.org/billfolder/billfolder2015-17/AB890%20RAND_RR650_ AnesthesiaManpower_2013.pdf

\(^9\) http://www.cdc.gov/vitalsigns/colorectalcancerscreening/
Anesthesia providers have voiced several concerns about technologies such as Sedasys. It must be emphasized that Sedasys is only the first and will not be the last of more and more advanced systems for the administration of either sedation or the intraoperative management of depth of anesthesia. Its introduction was delayed by a lengthy FDA approval process. The anesthesia community will and must continue to articulate and advocate for patient safety recognizing that with systems such as Sedasys patient selection is a critical area for both patient selections and exclusion criteria.

Experienced anesthesia providers also note that they can efficiently sedate patients for EGDs and colonoscopies more rapidly than can be achieved with the Sedasys system. This fails to account for total process time. As many other industries have recognized, rapid processing at one step is not the objective. Rather, the objective is total production (manufacturing) or patients treated (healthcare). The concept of “task time” recognizes that each step in complex processes must be coordinated. Total output rather than sub-step performance is the objective.

Computers will continue to help us deliver more precise and safer care to patients. Yet for the foreseeable future anesthesia will not become redundant. The United States Department of Labor Occupational Information Network still lists anesthesiology as a “Bright Outlook Occupation.” This means that anesthesiology is projected to grow much faster than average occupations. A fascinating study was conducted by Frey and Osborne of Oxford in 2013. They looked at “The Future of Employment: How Susceptible are Jobs to Computerization?” They discovered that three variables—social intelligence, creativity and perception and manipulation—are primary determinants in whether a job may be computerized. Dishwashers, court clerks and telemarketers all have jobs at high risk of being computerized. Anesthesiology does not.

To further this theme, I contacted David Dautor, PhD, Associate Department Head of the Department of Economics at the Massachusetts Institute of Technology. Technological change is one of his areas of expertise. His thoughts on computers in anesthesia are that:

- Anesthesiologists will remain indispensable
- Computers may reduce the number of anesthesiologists required per patient admission
- If anesthesia becomes cheaper and safer there may be an output expansion effect (increased volume)
- Medical occupations demand:
  - Deep technical expertise
  - Human flexibility
  - Problem solving
  - Creativity
  - Compassion
- Virtuous pairing of skills makes these jobs hard to replace with either machines or non-highly-trained workers

Surgery, procedural medicine and anesthesia techniques have advanced significantly. The techniques of proceduralists and surgeons progress continually to less invasive approaches. Each of these groups is treating patients with significant comorbidities who only a few decades ago would have been classified as being “too sick for anesthesia.” The computer power available to us has grown each decade and this trend will not diminish. It can be anticipated that computers and new anesthetic delivery systems will only increase in their capabilities. While the future of Sedasys as a system is unclear, we can anticipate other systems to enter the marketplace. Anesthesiologists need to adapt to these new technologies, demonstrating that we can provide outstanding anesthetic care to sicker patients, more efficiently, in a more cost effective manner with the humane treatments that our patients deserve and expect.

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Critical Issues to Consider When Exploring the Sale of Your Practice

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Given the heightened level of interest in acquisitions of independent anesthesiology groups, physician shareholders are being confronted with a myriad of questions. Many are finding that anesthesiology groups in the local region are being acquired by larger medical groups. What should their practice do? What would be the value of their practice if they sought to be acquired? What does the acquisition process look like and how could maintaining a steady course of non-action not result in the best long-term outcome?

Your Practice has Equity Value
Over the years, long-standing relationships have been developed with other healthcare providers and service contracts have been established with medical facilities, securing work for all the practice-employed physicians. A practice will accumulate a substantial amount of sweat equity, which has an equally substantial amount of economic value associated with it. Opportunity currently exists to monetize the value of this equity, and depending on regional market activities and the overall global economy, this opportunity may not always be available or as lucrative as it can be today.

Uncertainty is Prevalent
Anesthesiologists are currently enjoying high and steady market compensation rates with incomes that fall in the upper echelons within the healthcare physician provider spectrum.

However, considering the current landscape of the industry these statistics likely won’t maintain their relative position forever—especially in markets that are experiencing consolidation since rates will become more competitive, resulting in downward pressure.

As hospital service contracts come up for renegotiation through the RFP process, practices entrenched in these hospitals may find their subsidies and other benefit offerings thinning. Hospitals are facing increasing pressures to minimize operating costs and are being met with an increasing number of alternative providers as options to obtain necessary services. These alternatives are becoming bigger, more competitive and are offering more benefits to the hospitals, making the market as a service provider that much more competitive.

Additional uncertainty over reimbursement rates and models is increasing. Coordinated care is pressuring reimbursement rates down. The industry is experiencing a shift from fee-for-service to pay-for-performance, increasing burdensome requirements to report and maintain quality metric levels by the practice, resulting in greater operating costs and impacting smaller practices disproportionately to larger ones.

Bargaining Power
The industry is at a point in its life cycle when size matters, and many of the large buyers are bundling different physician and multispecialty services to gain critical mass and achieve greater bargaining power for contracts and resources. The regulatory environment is becoming increasingly tumultuous with recent legislated healthcare reforms, such as bundled payments, pay-for-performance, value-based purchasing and accountable care organizations.

Partnering with a larger organization in most cases provides your group access to greater resources, existing infrastructure and established business platforms to help address these challenges today, as well as the unforeseen obstacles that will arise in the future. It gives practices the support they need to negotiate with insurance carriers to improve (or at least maintain) current reimbursement rates. They have people whose full-time jobs are to look at managed care, figure out contracts and manage the collection of quality data that is used to improve outcomes.

Sophisticated, tried and true systems are in place to process billing and insurance claims and manage administrative functions to improve the overall process.

Critical Issues to Consider When Exploring the Sale of Your Practice

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without having groups solve these problems on their own. Physicians can focus on their clinical responsibilities without the administrative burden or managing the practice; overhead costs can be lowered.

**Status Quo**

The evolution of the anesthesiology industry is heading in a direction where the smaller, independent physician practice will encounter difficulties in competing with bigger and more capable competitors in the upcoming future. At the very least, this will result in a decrease in overall profitability. To maintain parity with today’s levels, a group would need to experience an increase in reimbursement rates and/or growth in the practice’s customer base, either via organic or inorganic growth maneuvers (pain clinics, ASCs, etc.) or through vertical integration (multi-specialty practices).

Inevitably, external market forces will threaten the ability of many practice models to continue independently. Regardless of any immediate plans or desire to undergo the transaction process, every independent anesthesiology practice group should begin discussing preparation initiatives that will streamline operations, reduce costs, improve financial transparency and other specific measures to increase their overall enterprise value. Furthermore, the group leadership should evaluate and keep apprised of the options available, so that when the necessity arises, familiarity exists with the process and educated decisions can be made.

**One-Time Sale**

Large strategic buyers with practices spanning regional and national geographies may be interested in acquiring your physician practice—in order to establish their presence in a new market or strengthen their position in an established one. These buyers may seek for the acquisition of up to 100 percent of the practice. Five to seven year employment commitment contracts for the selling physicians at fair market salaries and standard non-compete agreements are typical expectations from the buyer in return for this “cash-out.” In some deals, the buyer will seek to have ancillary transaction consideration tied to performance-based “earn-out” arrangements in order to incentivize post-transaction performance by the service provider group.

**Financial Recapitalizations**

Private equity firms (referred to as “financial buyers”) may be looking to invest in your practice via infusion of financial capital in return for a controlling stake in the practice—a cash-out of up to 80 percent of the equity value in the practice. They back privately-held mergers and acquisitions (M&A) companies generally seeking to create a financial “exit” for themselves, typically through the sale of the company to an even larger company or, less commonly, by attempting to “go public” and selling shares on the stock market. Their strategy is not to hold forever—they focus on a growth strategy where they make their businesses large enough to pull returns from their investments. These buyers are most suitable as partners to a practice where the leadership is interested in an active approach to growth. These firms typically bring financial and operational expertise to the table to undertake a rapid top-line and bottom-line expansion campaign. Once the growth strategy has been executed (in three to five years’ timeframe), the firm will look to sell ownership of the practice to another buyer, resulting in a cash-out of remaining ownership interest held by the original shareholders (commonly referred to as the “second bite of the apple”) at a substantially higher enterprise valuation.

**Alternative Employment**

If the opportunity to partner with a strategic or financial acquirer is no longer on the table, the group may continue its regular course or it may seek to be absorbed into employment within another group or with the hospital itself. While this provides opportunity to secure work and income with another group, this means any of the equity value and goodwill that was associated with original practice will be foregone—never to be realized. Physicians will receive fair market value salaries, but employment contracts are likely only to be short-term. This is often the least desirable scenario. With proper consultation and planning with the right M&A advisor—not a single dollar worth of value will be unnecessarily left behind.

**Transaction Process**

A physician group that decides that it wants to move forward with bringing another business partner into the picture should expect a transaction process that will run anywhere from six to twelve months. The stages of the process can be defined according to the following process chart:
Data Collection/CIM Creation—advisors work closely with key practice management and administration personnel to gather key financial and operational information about the practice to build a Confidential Information Memorandum (CIM), which will be used to market your practice. This will serve as an introduction to prospective buyers on what makes your group attractive and as a means of highlighting strengths of the practice. A qualified M&A advisor will work closely with you to develop this comprehensive brochure in order to expand on various aspects, including:

- General overview—history and background of the group, locations serviced, understanding of the ownership and reporting structure lines
- Management and operation model—key personnel biographies, staffing and service delivery models
- Operational and financial performance—case statistics and analysis of revenues, charges, collections and other accounting trends

Tactical Marketing—a campaign is thoughtfully planned and coordinated to reach the desired group of qualified transaction partners able and interested in merging with your practice. A qualified M&A advisor will solicit interest from these prospects on your behalf, coordinate for meetings with these suitors and strategize subsequent steps with your group in considering all viable options. In this stage, attention is given to differentiating characteristics among the buyers, particularly:

- Strategic vision—prospective acquirer’s business plan alignment with the interests of practice stakeholders
- Synergies/value-adds—business relationships, reporting and information systems, shared resources, negotiation leverage and payer rate arbitrage

Letter-of-Intent (LOI)—once the most suitable partners have been evaluated, the process of narrowing down the potential acquirers takes place. M&A advisors are critical in this stage, as they aid in the negotiation to arrive at favorable terms for the selling practice. Review of key factors, not limited to the cash that is being offered for the ownership, include:

- Consideration offered—ancillary to cash offer and any contingencies tied to future receipts
- Employment and benefits—post-transaction compensation rates, employment conditions and terms, and benefits packages

Preliminary terms of sale and an exclusivity agreement are drawn up in the form of a LOI and entered into between the parties, consummating the due diligence process for the buyer and limiting the ability of the seller to solicit offers from any other suitors.

Due Diligence—the buyer will initiate the comprehensive audit review process of the practice, performing procedures to assess the reliability of any assumptions upon which the buyer based its purchase price valuations. This process requires the business to submit numerous legal and financial records requests to the buyer for their evaluation, involving a significant amount of secondary requests and follow-up inquiries. A qualified M&A advisor will prepare the practice and its management to efficiently complete the process, will assume the bulk of the responsibilities in order to limit the impact on everyday business operations, and will help overcome obstacles encountered along the way.

Closing—upon conclusion of the diligence process, a Definitive Purchase Agreement is drafted according to the final terms agreed upon between the parties. Business continues as usual under the new ownership structure.

Selection Of Advisor

Before heading down the route selling of the practice, it is important for leadership to understand that hiring the right advisor is crucial for executing a successful transaction. The ideal M&A professionals will understand it is not only about selling your practice; it is also about understanding your practice, your partners and your unique value—in addition to finding both the optimal economics, as well as “the right fit and best partner” for your group.

The right M&A professionals will have extensive experience specific to the anesthesiology sector in order to advise you on a successful transaction. They will have completed numerous transactions with other independently-owned physician practices and have worked intimately with all of the prospective buyers of anesthesiology groups. A qualified M&A team

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will have an advisory board of healthcare professionals, including anesthesiologists, who have practiced, sold their groups, worked for large national anesthesiology companies and consulted on mergers and acquisitions of anesthesiology groups.

The right M&A professionals will be experts in handling communication among all of the interested parties within the transaction. They will recognize the importance of appropriate, timely and well-designed, on-point communication to the various internal constituencies.

- **The Executive Committee or Equivalent**—keeping them involved on issues and updated on progress being made, walking them through the offers and differentiate the relative pros and cons
- **Shareholders**—keeping them incrementally informed, educating them about the process, potential structures, employment provisions and other details of the transaction as it impacts life after the deal with their new partner
- **Employees**—leading town hall meetings with all the stakeholders to help introduce the Buyer and explain, amongst other things, how compensation and benefits will work post-closing
- **Customers**—strategizing on when and how best to inform them of the transaction

The benefits of hiring the most suitable M&A advisors when your group is investigating a transaction opportunity by far outweigh any cost savings thought to have been realized when considering anything less. The prime opportunity for the sale of your independent practice will only come around once—this is a consideration that deserves to be taken seriously. Have the best professionals on your side of the negotiation table.

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**The Road Not Taken**

**Jody Locke, CPC**

Vice President of Anesthesia and Pain Management Services, Anesthesia Business Consultants, Jackson, MI

One of Robert Frost’s most popular poems is *The Road Not Taken*. It is about two paths that diverge in the woods. It is a wonderful and powerful metaphor for the decisions we make in life. By selecting one option we inevitably forgo another. More often than not this results in endless speculation as to whether it was the right choice. And so it is with the strategic decision to sell one’s anesthesia practice. The allure of being part of a bigger, stronger and better-managed entity is a powerful draw but does it really result in a more secure practice situation? That is the question of the day.

Anesthesia providers are a curious breed. They are credited with having the shortest decision cycle in medicine. They routinely make critical life and death decisions in a matter of seconds. Ironically, despite their facility in the operating room, when presented with major strategic decisions pertaining to their practice they often freeze like deer caught in the headlights. One can explain this on the basis of their training, which involves clinical decision trees that have been assiduously memorized. In other words they perform consistently in the known environment of the operating room and delivery suite. We often joke that physicians and CRNAs are not business people. Although some are, many have simply focused their energy on their professional training and clinical skills. Such an intense focus on managing
patients safely through the trauma of surgery has resulted in a population of providers who tend to be extremely cautious and risk-averse in their personal and business lives. Their comfort zone is defined by the operating room and the processes over which they have learned to exercise a modicum of control.

Anesthesia providers are known for their independence. For them, anesthesia is both art and science; a unique creation that responds to the unique requirements of patient, surgeon and surgical procedure. Some have suggested that even the notion of an anesthesia practice is an anachronism. Most anesthesia groups operate more as professional business fraternities than as rigorous business entities. The typical American anesthesia practice provides just enough structure and focus to ensure a viable franchise that collects an adequate income to provide a reasonable income to its members without imposing any undue constraints or limitations on the clinical activities of its members. For most, partnership or shareholder status is the medical equivalent of tenure where cause for termination is almost unknown.

How curious is it, then, that so many of these loose confederations of providers are willingly and eagerly selling out to aggregators which offer so little in the way of long term security or protection? What does this say about the current state of healthcare in this country? What does it say about the nature of the specialty and its practitioners? What is the problem to which selling one’s practice is the perceived best alternative? And when a practice decides to merge or sell out, how do its members know they have chosen the best path? There is a lot of wishful thinking in such decisions, but more than anything it is blind faith since no one can really predict the outcome.

Such change can only be motivated by fear or hope, and in the case of what is taking place in the specialty of anesthesia, it is obvious that fear is the predominant motivator. Consider some of the most significant recent developments in U.S. healthcare. There is nothing to reassure providers that things will work out for the best. Just the opposite occurs, from a provider’s perspective; each new regulation, consolidation or proposed quality metric only reinforces a perception that the system is out of control. More service will be required for less pay.

If U.S. healthcare is a boat that has been quietly cruising a predictable course these past few decades, most would agree that it has suddenly been thrust out into uncharted waters. The passage of HIPAA was the first wake-up call. While compliance had been a topic of discussion prior to 1996, the year of HIPAA’s enactment, it became a major concern. One could even say that U.S. medicine has evolved through three phases over the last few decades. In the seventies and eighties one collected what one billed. In the late eighties and nineties managed care changed the rules of engagement so that one got paid what one negotiated. Now it can be said—with only slight exaggeration—that one gets to keep what does not get taken away in a compliance audit.

While most physicians could deal with the implications of HIPAA, the passage of healthcare reform and the implementation of the Affordable Care Act, aka Obamacare, has been an entirely different matter. It is the very nature of the legislation that it presupposes structural changes in the market for healthcare, few of which are actually defined. At every level of healthcare delivery entities are struggling to envision a future that is as clear as the forest paths Frost described and to position themselves to be serious players. Never has U.S. healthcare seen such an explosion of activity. Two themes appear to be driving all the strategic considerations: quality and cost, for the underlying assumptions of Obamacare are that U.S. healthcare is too inconsistent and too expensive. Americans pay a huge premium for less than optimum care.

Capital has a curious way of finding its way into such situations. Investors love to think that one man’s challenge is another’s opportunity. Businessmen are eager to bring order to the chaos of healthcare. The amount of venture capital that has flowed into the specialty of anesthesia in recent years is impressive. It is the availability of such capital to buy and aggregate anesthesia practices that is so dramatically changing the landscape. Obviously there are those who believe that the application of better management will result in better, cheaper and more profitable healthcare. By all accounts, however, one must acknowledge that the proposed outcome is still much more of a concept than a reality.

The current environment has given new life to an old aphorism. The beliefs and strategies that have gotten us to where we are today will not get us to where we want to be tomorrow. American anesthesia providers have always believed that if they consistently provided quality care all the rest of their issues would take care of themselves. Ironically, they may have done too good a job. Quality is now a given. Anesthesia care has become a commodity.

And so anesthesia providers have become increasingly anxious about the future of their practices. They are starting to feel impotent, that the game is rigged, that they cannot compete with bigger,
slicker and more aggressive competitors. And so they ask themselves, is bigger better? With increasing frequency they conclude that it must be, not because they know this to be true, but because it appears to be the only alternative.

As scientists, anesthesia providers like to analyze things objectively. The art of administering anesthesia is based on a feedback paradigm where the availability of reliable data about a patient's physiology allows for effective decision-making. How, though, does one make business decisions when the desired feedback is so illusory and delayed? While the desired outcome of each anesthetic is clearly defined a priori, what is the desired outcome of strategic decision-making? Thoughtful observers suggest three:

- Job security
- Increased income for work performed
- Control over one's destiny

If the motivation to sell or merge one's practice is concern for the future, which is the most common concern of most practices today, then this requires careful due diligence. While it is true that larger entities have the ability to ensure providers will have work, they cannot necessarily guarantee any specific work situation. There is growing evidence that hospital administrations are increasingly concerned about the power of anesthesia mega-groups. Many an anesthesia practice has aggressively pursued a merger or acquisition only to learn that such an act would result in termination of the contract.

While it is true that large anesthesia practices have the ability to negotiate better rates with payers, this does not necessarily translate into better physician or CRNA compensation. For those entities that are investor owned, increased contract rates are viewed as integral to generating profits as is the ability to drive down the cost of providing care. Most observers agree that the more aggregation that occurs in anesthesia, the more this will result in reduced provider compensation. The strategy is simple. Today's aggregators offer new graduates lower salaries but predictability in lifestyle, a formula that seems to be playing well. What they also offer is a career path for those who have management ability. The formula ties the reward of higher compensation to the risks of managing other providers and reducing the overall cost of care.

And to the third litmus test, control over one's destiny, what is the impact of adding one's name to a longer list of providers? Clearly it diminishes an individual's influence or control, unless that individual is politically astute and can be an active member of the management team. But this objective may actually be a chimera. While anesthesia providers love to think they have a certain degree of autonomy and independence, this probably only refers to what happens within the four walls of the operating room. Outside the O.R. no specialty is more captive to the requirements and expectations of its customers.

So why do so many practices and providers so willingly give up what seemed so important to them? Quite simply, most have come to believe they have no alternative, or at least no better alternative. Many may be right but most are simply unwilling to make the changes necessary to meet new market conditions. This perspective is consistent with the long-held belief that all that really matters is good outcomes. Most practices that see themselves as being vulnerable or at risk could probably fix their practice and secure their own future. To do so would be a challenge. What happens instead is that they let someone else impose a better solution.

There is a classic admonition that one will never get rich working for someone else. Most anesthesia providers do not pick the specialty to get rich. Most pick the specialty because they are fascinated by the science, like the work and want to make a difference in patients' lives. They see themselves as problem-solvers and decision-makers. It is ironic that the very skills that make most anesthesiologists and CRNAs so effective in the management of their patients don't get applied to the management of their practices. Some large anesthesia practices and aggregators appear to have developed a successful formula for success but these are the exceptions. Many others are still focused on getting big without really having formulated a strategy to ensure security, income and control of destiny.

Ultimately, this is a classic buy-or-make decision. We pay for a service that we cannot provide for ourself. Anesthesia practices either do their own billing or they outsource it to a vendor. The decision to sell or merge should be viewed through the same lens. If the proposed solution does not create more value than you could create yourself then you might be deluding yourself by thinking it is a better option. Frost was prescient. How often do we pick a path just because we think it will be better or easier and how do we know whether it was the right path? That is the question that will haunt us for years to come.

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management for ABC. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He will be a key executive contact for the group should it enter into a contract for services with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.
CONFIDENTIALITY IN THE PEER REVIEW PROCESS: WHAT DOES IT MEAN AND WHAT IS COVERED? PART II

Neda M. Ryan, Esq.
Corporate Compliance Attorney, Anesthesia Business Consultants, Jackson, MI

In the Winter 2016 issue of The Communique, we offered Part I of a summary of state laws (Alabama through Iowa) involving the peer review process. Here we are continuing that summary with the remaining states (Kansas through Wyoming).

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<tr>
<td>KS</td>
<td>Kan. Stat. § 65-4915(b)</td>
<td>The reports, statements, memoranda, proceedings, findings and other records submitted to or generated by peer review committees or officers shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible in evidence in any judicial or administrative proceeding. Information contained in such records shall not be discoverable or admissible at trial in the form of testimony by an individual who participated in the peer review process. The peer review officer or committee creating or initially receiving the record is the holder of the privilege established by this section. This privilege may be claimed by the legal entity creating the peer review committee or officer, or by the commissioner of insurance for any records or proceedings of the board of governors. (c) Subsection (b) shall not apply to proceedings in which a healthcare provider contests the revocation, denial, restriction or termination of staff privileges or the license, registration, certification or other authorization to practice of the healthcare provider.</td>
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<td>Kentucky</td>
<td>Ky Rev. Stat. § 311.377(2)</td>
<td>At all times in performing a designated professional review function, the proceedings, records, opinions, conclusions and recommendations of any committee, board, commission, medical staff, professional standards review organization or other entity, shall be confidential and privileged and shall not be subject to discovery, subpoena or introduction into evidence, in any civil action in any court or in any administrative proceeding before any board, body or committee, whether federal, state, county or city, except as specifically provided with regard to the board in KRS 311.605(2). This subsection shall not apply to any proceedings or matters governed exclusively by federal law or federal regulation.</td>
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<tr>
<td>LA</td>
<td>La. Rev. Stat. § 13:3715.3A(1)</td>
<td>All records, notes, data, studies, analyses, exhibits and proceedings of: (1) Any public hospital committee, medical organization peer review committee, any nationally recognized improvement agency or commission, including but not limited to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any committee or agency thereof, or any healthcare licensure agency of the Louisiana Department of Health and Hospitals, public hospital board while conducting peer reviews, dental association peer review committee, professional nursing association peer review committee, extended care facility committee, nursing home association peer review committee, peer review committee of a group medical practice of twenty or more physicians, peer review committee of a freestanding surgical center licensed pursuant to R.S. 40:2131 et seq., or health maintenance organization peer review committee, including but not limited to the credentials committee, the medical staff executive committee, the risk management committee, or the quality assurance committee any committee determining a root cause analysis of a sentinel event, established under the bylaws, rules, or regulations of such organization or institution, or (2) Any hospital committee, the peer review committees of any medical organization, dental association, professional nursing association, nursing home association, social workers association, group medical practice of twenty or more physicians, nursing home, ambulatory surgical center licensed pursuant to R.S. 40:2131 et seq., ambulance service company, health maintenance organization, any nationally recognized improvement agency or commission, including but not limited to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any committee or agency thereof, or any healthcare licensure agency of the Louisiana Department of Health and Hospitals, or healthcare provider as defined in R.S. 40:1299.41(A), or extended care facility committee, including but not limited to the credentials committee, the medical staff executive committee, the risk management committee, or the quality assurance committee, any committee determining a root cause analysis of a sentinel event, established by the peer review committees of a medical organization, dental organization, group medical practice of twenty or more physicians, social workers association, ambulatory surgical center licensed pursuant to R.S. 40:2131 et seq., ambulance service company, health maintenance organization, or healthcare provider as defined in R.S. 40:1299.41(A) or private hospital licensed under the provisions of R.S. 40:2100 et seq., shall be confidential wherever located and shall be used by such committee and the members thereof only in the exercise of the proper functions of the committee and shall not be available for discovery or court subpoena regardless of where located, except in any proceedings affecting the hospital staff privileges of a physician, dentist, psychologist or podiatrist, the records forming the basis of any decision adverse to the physician, dentist, psychologist, or podiatrist may be obtained by the physician, dentist, psychologist or podiatrist only. However, no original record or document, which is otherwise discoverable, prepared by any person, other than a member of the peer review committee or the staff of the peer review committee, may be held confidential solely because it is the only copy and is in the possession of a peer review committee.</td>
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<tr>
<td>Maine</td>
<td>Me. Rev. Stat. § 529-A</td>
<td>All proceedings and records of proceedings concerning medical staff reviews and hospital reviews conducted by committees of physicians and other healthcare personnel on behalf of hospitals located within the State, when these reviews are required by state or federal law or regulations or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation are confidential and are exempt from discovery without a showing of good cause.</td>
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1 Special thanks is given to Amy Bell for her assistance in preparing this article.
**CONFIDENTIALITY IN THE PEER REVIEW PROCESS: WHAT DOES IT MEAN AND WHAT IS COVERED? PART II**

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<tr>
<td>Maryland</td>
<td>Md. Code HEALTH OCC. § 1-401</td>
<td>Except as otherwise provided in this section, the proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action. The proceedings, records, and files of a medical review committee are confidential and are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee if requested in certain statutorily specified instances.</td>
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<tr>
<td>Massachusetts</td>
<td>Mass. Gen. Laws ch. 111 § 204</td>
<td>Except as otherwise provided in this section, the proceedings, reports and records of a medical peer review committee shall be confidential and shall be exempt from the disclosure of public records under section 10 of chapter 66 but shall not be subject to subpoena or discovery, or introduced into evidence, in any judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, pharmacy, social work, or psychology or by the department of public health pursuant to chapter 111C, and no person who was in attendance at a meeting of a medical peer review committee shall be permitted or required to testify in any such judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, pharmacy, social work or psychology or by the department of public health pursuant to chapter 111C, as to the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, deliberations or other actions of such committee or any members thereof. Documents, incident reports or records otherwise available from original sources shall not be immune from subpoena, discovery or use in any such judicial or administrative proceeding merely because they were presented to such committee in connection with its proceedings. Nor shall the proceedings, reports, findings and records of a medical peer review committee be immune from subpoena, discovery or use as evidence in any proceeding against a member of such committee to establish a cause of action pursuant to section eighty-five N of chapter two hundred and thirty-one; provided, however, that in no event shall the identity of any person furnishing information or opinions to the committee be disclosed without the permission of such person. Nor shall the provisions of this section apply to any investigation or administrative proceeding conducted by the boards of registration in medicine, pharmacy, social work or psychology or by the department of public health pursuant to chapter 111C. No proceeding, report or record of a medical peer review committee obtained hereunder and disclosed in an action pursuant to section eighty-five N of chapter two hundred and thirty-one or a proceeding before an administrative body, shall be subject to subpoena or discovery, or introduced into evidence in judicial or administrative proceedings other than those proceedings or investigations that are statutorily specified.</td>
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<td>Michigan</td>
<td>MCLA § 331.533, MCLA § 331.532, MCLA § 333.16238, MCLA § 333.21515</td>
<td>The identity of a person who is the subject of a review is not discoverable as well as the record of a proceeding, reports, findings and conclusions. Exceptions include the release of records to advance healthcare research or healthcare education; to maintain the standards of the healthcare professions; to protect the financial integrity of any governmental funded program; to provide evidence relating to the ethics or discipline of a healthcare provider, entity or practitioner; to review the qualifications, competence, and performance of a healthcare professional with respect to the selection and appointment of the healthcare professional to the medical staff of a health facility and to comply with section 20175 of the Public Health Code, 1978 PA 368, MCL § 333.20175.</td>
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<tr>
<td>Minnesota</td>
<td>Minn. Stat. § 145.64(11)</td>
<td>Unless otherwise excepted, data and information acquired by a review organization, in the exercise of its duties and functions, or by an individual or other entity acting at the direction of a review organization, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person’s knowledge, but a witness cannot be asked about the witness’ testimony before a review organization or opinions formed by the witness as a result of its hearings. The confidentiality protection and protection from discovery or introduction into evidence provided in this subdivision shall also apply to the governing body of the review organization and shall not be waived as a result of referral of a matter from the review organization to the governing body or consideration by the governing body of decisions, recommendations or documentation of the review organization.</td>
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<tr>
<td>Mississippi</td>
<td>Miss. Code § 41-63-911</td>
<td>In order to encourage medical review activity, the proceedings and records of any medical review committee shall be confidential and shall not be subject to discovery or introduction into evidence in any civil action arising out of the matters which are the subject of evaluation and review by such committee. No person who was in attendance at a meeting of such committee shall be permitted or required to testify in any civil action regarding any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions or other actions of the committee or its members. However, information, documents or records otherwise discoverable or admissible from original sources are not to be construed as immune from discovery or use in any civil action merely because they were presented during the proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to other matters within his knowledge. Provided, however, a witness shall not be questioned concerning his participation on or testimony before such committee or opinions formed by him as a result of such committee hearings or proceedings.</td>
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<td>Missouri</td>
<td>Mo. Rev. Stat. § 537-335</td>
<td>The interviews, memoranda, proceedings, findings, deliberations, reports and minutes of peer review committees, or the existence of the same, concerning the healthcare provided any patient are privileged and shall not be subject to discovery, subpoena, or other means of legal compulsion for their release to any person or entity or be admissible into evidence in any judicial or administrative action for failure to provide appropriate care. Except as otherwise provided in this section, no person who was in attendance at any peer review committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding, or to disclose any opinion, recommendation, or evaluation of the committee or board, or any member thereof; provided, however, that information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee or board or about opinions formed as a result of such committee hearings. The disclosure of any interview, memoranda, proceedings, findings, deliberations, reports, or minutes to any person or entity, including but not limited to governmental agencies, professional accrediting agencies, or other healthcare providers, whether proper or improper, shall not waive or have any effect upon its confidentiality, non-discourability, or non-admissibility.</td>
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<tr>
<td>Montana</td>
<td>Mont. Code § 57-2-201</td>
<td>The proceedings and records of peer review are not subject to discovery or introduction into evidence in any proceeding. However, information otherwise discoverable or admissible from an original source is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before the committee, nor is a member of the committee or other person appearing before it to be prevented from testifying as to matters within his personal knowledge and in accordance with the other provisions of this section, but such witness cannot be questioned about testimony or other proceedings before any healthcare review committee or board or about opinions formed as a result of such committee hearings. The disclosure of any interview, memoranda, proceedings, findings, deliberations, reports, or minutes to any person or entity, including but not limited to governmental agencies, professional accrediting agencies, or other healthcare providers, whether proper or improper, shall not waive or have any effect upon its confidentiality, non-discourability, or non-admissibility.</td>
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<tr>
<td>Nebraska</td>
<td>Neb. Rev. Stat. § 71-7912</td>
<td>The proceedings, records, minutes, and reports of a peer review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action. No person who attends a meeting of a peer review committee, works for or on behalf of a peer review committee, provides information to a peer review committee, or participates in a peer review activity as an officer, director, employee, or member of the governing board of a facility which is a healthcare provider shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings or activities of the peer review committee or as to any findings, recommendations, evaluations, opinions, or other actions of the peer review committee or any members thereof. Nothing in this section shall be construed to prevent discovery or use in any civil action of medical records, documents or information otherwise available from original sources and kept with respect to any patient in the ordinary course of business, but the records, documents, or information shall be available only from the original sources and cannot be obtained from the peer review committee’s proceedings or records.</td>
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<td>Nevada</td>
<td>Nev. Rev. Stat. § 49.265</td>
<td>The proceedings and records of:</td>
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<td>(1) Organized committees of hospitals and organized committees of organizations that provide emergency medical services pursuant to the provisions of chapter 450B of NRS, having the responsibility of evaluation and improvement of the quality of care rendered by those hospitals or organizations;</td>
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<td>(2) Review committees of medical or dental societies; and</td>
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<td>(3) Edical review committees of a county or district board of health that certifies, licenses or regulates providers of emergency medical services pursuant to the provisions of chapter 450B of NRS, but only when such committees function as peer review committees, are not subject to discovery proceedings. Moreover, no person who attends a meeting of any such committee may be required to testify concerning the proceedings at the meeting.</td>
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<td>New Hampshire</td>
<td>N.H. Rev. Stat. § 151:13-a</td>
<td>Records of a hospital committee organized to evaluate matters relating to the care and treatment of patients or to reduce morbidity and mortality and testimony by hospital trustees, medical staff, employees, or other committee attendees relating to activities of the quality assurance committee shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented to a quality assurance program, and any person who supplies information or testifies as part of a quality assurance program, or who is a member of a quality assurance program committee, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her testimony before such program, or opinions formed by him or her, as a result of committee participation. Further, a program’s records shall be discoverable in either of the following cases: A judicial or administrative proceeding brought by a quality assurance committee to revoke or restrict the license, certification, or privileges of a physician or hospital staff member; or a proceeding alleging repetitive malicious action and personal injury brought against a physician or hospital staff member.</td>
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<td>New Jersey</td>
<td>None.</td>
<td>All data and information acquired by a review organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization or in a judicial appeal from the action of the review organization. No person described in Section 41-9-5 NMSA 1978 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of the review organization, in a judicial appeal from the action of the review organization or when subpoenaed by the New Mexico medical board. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of a review organization be prevented from testifying as to matters within the person’s knowledge, but a witness cannot be asked about opinions formed by the witness as a result of the review organization’s hearings. Nothing in this section shall be construed to permit the New Mexico medical board to issue subpoenas requesting that any person appear to testify regarding what transpired at a meeting of a review organization or opinions formed as a result of review organization proceedings.</td>
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<td>New Mexico</td>
<td>N.M. Stat. § 41-8-5</td>
<td>None.</td>
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<tr>
<td>New York</td>
<td>N.Y. Pub. Health Law § 2805-m</td>
<td>Information collected during a peer review must be kept confidential. However, it can be released to the department or to another hospital to the extent the information is available. Statements made by a person in attendance who is a party to an action or the subject matter are discoverable.</td>
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<tr>
<td>North Carolina</td>
<td>N.C. Gen. Stat. § 131E-95</td>
<td>The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.</td>
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<td>North Dakota</td>
<td>N.D. Cent. Code § 22-34-02</td>
<td>Peer review records are confidential and may be used by a peer review organization and the organization members only for conducting a professional peer review. Peer review records are privileged and are not subject to subpoena or discovery or introduction into evidence in any civil or administrative action, except for the following: records gathered from an original source that is not a peer review organization; testimony from any person as to matters within that person's knowledge, provided the information was not obtained by the person as a result of the person's participation in a professional peer review; or peer review records subpoenaed in an investigation conducted by an investigative panel of the North Dakota board of medicine or subpoenaed in a disciplinary action before the North Dakota board of medicine.</td>
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<td>N.D. Cent. Code § 22-34-68.1</td>
<td>Proceedings and records within the scope of a peer review committee of a healthcare entity shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a healthcare entity or healthcare provider, including both individuals who provide healthcare and entities that provide healthcare, arising out of matters that are the subject of evaluation and review by the peer review committee. No individual who attends a meeting of a peer review committee, serves as a member of a peer review committee, works for or on behalf of a peer review committee, or provides information to a peer review committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the peer review committee or as to any finding, recommendation, evaluation, opinion, or other action of the committee or a member thereof. Information, documents or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were produced or presented during proceedings of a peer review committee, but the information, documents or records are available only from the original sources and cannot be obtained from the peer review committee's proceedings or records.</td>
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<tr>
<td></td>
<td>N.D. Cent. Code § 22-34-68</td>
<td>All information, interviews, reports, statements, memoranda or other data furnished to an in-hospital staff committee, and any findings or conclusions may not be used or offered or received in evidence in any legal proceeding of any kind or character, and any attempt to use or offer any such information, interviews, reports, statements, memoranda or other data, findings, or conclusions, or any part thereof, unless waived by the interested parties shall constitute prejudicial error in any such proceeding.</td>
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<tr>
<td>Oklahoma</td>
<td>Okla. St. tit. 63 § 1-1709</td>
<td>All data brought before a peer review body is privileged and is not admissible in evidence in any judicial, administrative, arbitration or mediation proceeding. This does not affect the admissibility in evidence of records dealing with a patient care and treatment, other than data or information obtained through service on, or as an agent for, a peer review body. Peer review body includes tissue committees, governing bodies or committees including medical staff committees of a licensed healthcare facility, medical staff committees of the Department of Corrections and similar committees of professional societies, a healthcare service contractor, an emergency medical service provider, or any other medical group or provider of medical services in connection with bona fide medical research, quality assurance, utilization review, credentialing, education, training, supervision or discipline of physicians or other healthcare providers or in connection with the grant, denial, restriction or termination of clinical privileges at a healthcare facility. Peer review body also includes utilization review and peer review organizations. “Data” means all oral communications or written reports to a peer review body, and all notes or records created by or at the direction of a peer review body, including the communications, reports, notes or records created in the course of an investigation undertaken at the direction of a peer review body. A person serving on or communicating information to any peer review body or person conducting an investigation must not be examined as to any communication to or from, or the findings of, that peer review body or person. This does not apply to proceedings in which a healthcare practitioner contests the denial, restriction or termination of clinical privileges by a healthcare facility or the denial, restriction or termination of membership in a professional society or any other healthcare group. However, any data disclosed in those proceedings shall not be admissible in any other judicial, administrative, arbitration or mediation proceeding.</td>
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<tr>
<td>Oregon</td>
<td>Or. Rev. Stat. § 41.675</td>
<td>All data brought before a peer review body is privileged and is not admissible in evidence in any judicial, administrative, arbitration or mediation proceeding. This does not affect the admissibility in evidence of records dealing with a patient care and treatment, other than data or information obtained through service on, or as an agent for, a peer review body. Peer review body includes tissue committees, governing bodies or committees including medical staff committees of a licensed healthcare facility, medical staff committees of the Department of Corrections and similar committees of professional societies, a healthcare service contractor, an emergency medical service provider, or any other medical group or provider of medical services in connection with bona fide medical research, quality assurance, utilization review, credentialing, education, training, supervision or discipline of physicians or other healthcare providers or in connection with the grant, denial, restriction or termination of clinical privileges at a healthcare facility. Peer review body also includes utilization review and peer review organizations. “Data” means all oral communications or written reports to a peer review body, and all notes or records created by or at the direction of a peer review body, including the communications, reports, notes or records created in the course of an investigation undertaken at the direction of a peer review body. A person serving on or communicating information to any peer review body or person conducting an investigation must not be examined as to any communication to or from, or the findings of, that peer review body or person. This does not apply to proceedings in which a healthcare practitioner contests the denial, restriction or termination of clinical privileges by a healthcare facility or the denial, restriction or termination of membership in a professional society or any other healthcare group. However, any data disclosed in those proceedings shall not be admissible in any other judicial, administrative, arbitration or mediation proceeding.</td>
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<tr>
<td>Pennsylvania</td>
<td>63 Pa. Stat. § 425.4</td>
<td>The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a professional healthcare provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof. Provided, however, that information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, but the said witness cannot be asked about his testimony before such a committee or opinions formed by him as a result of said committee hearings.</td>
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</table>
## State | Citation(s) | Brief Description
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### Rhode Island<br>§ 1443 | R.I. Gen. Laws § 23-17-25 | Neither the proceedings nor the records of peer review boards are subject to discovery or admissible in evidence in any case save litigation arising out of the imposition of sanctions upon a physician. However, any imposition or notice of a restriction of privileges or a requirement of supervision imposed on a physician for unprofessional conduct is subject to discovery and admissible in any proceeding against the physician for performing, or against any healthcare facility or healthcare provider which allows the physician to perform the medical procedures which are the subject of the restriction or supervision during the period of the restriction or supervision or subsequent to that period. This does not apply to records made in the regular course of business by a hospital or other provider of healthcare information. Documents or records otherwise available from original sources are not to be construed as immune from discovery or used in any civil proceedings merely because they were presented during the proceedings of the committee.

### South Carolina<br>§ 160.007 | S.C. Code § 44-7-382 | All proceedings of, and all data, documents, records, and information prepared or acquired by, a licensed hospital, its parent, subsidiaries, healthcare system, committees, whether permanent or ad hoc, including the hospital’s governing body, or physician practices owned by the hospital (its parent or subsidiaries), relating to the following are confidential:
(a) sentinel event investigations or root cause analyses, or both, as prescribed by the joint commission or any other organization under whose accreditation a hospital is deemed to meet the Centers for Medicare and Medicaid Services’ conditions of participation;
(b) investigations into the competence or conduct of hospital employees, agents, members of the hospital’s medical staff or other practitioners, relating to the quality of patient care, and any disciplinary proceedings or fair hearings related thereto;
(c) quality assurance reviews;
(d) the medical staff credentialing process;
(e) reports by a hospital to its insurance carriers;
(f) reviews or investigations to evaluate the quality of care provided by hospital employees, agents, members of the hospital’s medical staff, or other practitioners; or
(g) reports or statements, including, but not limited to, those reports or statements to the National Practitioner Data Bank and the South Carolina Board of Medical Examiners, that provide analysis or opinion (including external reviews) relating to the quality of care provided by hospital employees, agents, members of the hospital’s medical staff, or other practitioners; or
(h) incident or occurrence reports and related investigations, unless the report is part of the medical record.

Data, documents, records, or information which are otherwise available from original sources are not confidential and are not immune from discovery from the original source under this section or use in a civil action merely because they were acquired by the hospital.

### South Dakota<br>§ 4-26.1 | S.C. Code § 36-4-26.1 | The proceedings, records, reports, statements, minutes or any other data whatsoever, of certain committees relating to peer review activities are not subject to discovery or disclosure under and are not admissible as evidence in any action of any kind in any court or arbitration forum, unless an exception applies. No person in attendance at any meeting of any such committee is required to testify as to what transpired at such meeting.

### Tennessee<br>§ 161.032 | Tenn. Code § 68-11-272 | Records of a Quality Improvement Committee (QIC) and testimony or statements by a healthcare organization’s officers or directors, trustees, healthcare providers, administrative staff, employees or other committee members or attendees relating to activities of the QIC shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena or admission into evidence in any judicial or administrative proceeding. Any person who supplies information, testifies or makes statements as part of a QIC may not be required to provide information as to the information, testimony or statements provided to or made before such a committee or opinions formed by such person as a result of committee participation.

Any information, documents or records, which are not produced for use by a QIC or which are not produced by persons acting on behalf of a QIC, and are otherwise available from original sources, shall not be construed as immune from discovery or use in any judicial or administrative proceedings merely because such information, documents or records were presented during proceedings of such committee.

### Texas<br>§ 160.007 | Tex. Occ. Code § 161.032 | The records and proceedings of a medical committee are confidential and are not subject to court subpoena.

Unless an exception applies or a court finds the records relevant, each proceeding or record of a medical peer review committee is confidential and any communication made to a medical peer review committee is privileged.

### Utah<br>§ 26-25-3 | Utah Code § 160.007 | All information, interviews, reports, statements, memoranda, or other data furnished to a peer review committee, professional review organization, or another organization statutorily identified, and any findings or conclusions resulting from those studies are privileged communications and are not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

### Vermont<br>§ 1645 | Vt. Stat. tit. 26 § 1645 | Unless otherwise excepted, the proceedings, reports, and records of a peer review committee’s information and evidence shall be confidential and privileged, and shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are subject to evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any findings, recommendations, evaluations, opinions, or other actions of such committees or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such action merely because they were presented during the proceedings of such committee, nor shall any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his or her knowledge, but such witness shall not be asked about his or her testimony before such committee or about opinions formed by him or her as a result of such committee hearings.
**CONFIDENTIALITY IN THE PEER REVIEW PROCESS: WHAT DOES IT MEAN AND WHAT IS COVERED? PART II**

*Continued from page 25*

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<tr>
<td>Virginia</td>
<td>Va. Code § 8.01-581.17</td>
<td>The proceedings, minutes, records and reports of any (i) medical staff committee, utilization review committee, or (ii) other committee, that provides a centralized credentialing service; or (iii) quality assurance, quality of care, or peer review committee established pursuant to guidelines approved are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications. Oral communications regarding a specific medical incident involving patient care, made to a quality assurance, quality of care, or peer review committee established pursuant to clause (iii), shall be privileged only to the extent made more than 24 hours after the occurrence of the medical incident. Nothing in this section shall be construed as providing any privilege with respect to any factual information regarding specific patient healthcare or treatment, including patient healthcare incidents, whether oral, electronic, or written. However, the analysis, findings, conclusions, recommendations, and the deliberative process of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity specified by statute, as well as the proceedings, minutes, records, and reports, including the opinions and reports of experts, of such entities shall be privileged in their entirety under this section. Information known by a witness with knowledge of the facts or treating healthcare provider is not privileged or protected from discovery merely because it is provided to a committee, board, group, commission, or other entity specified by statute, and may be discovered by deposition or otherwise in the course of discovery. A person involved in the work of the entities referenced in herein shall not be made a witness with knowledge of the facts by virtue of his involvement in the quality assurance, peer review or credentialing process. Nothing in this section shall be construed as providing any privilege with respect to a patient, whose treatment is at issue, in the ordinary course of business of operating a hospital, emergency medical services agency, community services board, or behavioral health authority nor to any facts or information contained in medical records, nor shall this section preclude or affect discovery of or production of evidence relating to hospitalization or treatment of such patient in the ordinary course of the patient's hospitalization or treatment. However, the proceedings, minutes, records, reports, analysis, findings, conclusions, recommendations, and the deliberative process, including opinions and reports of experts, of any medical staff committee, utilization review committee, or other committee, board, group, commission, or other entity specified by statute shall not constitute medical records, are privileged in their entirety, and are not discoverable. Notwithstanding any other provision, reports or patient safety data in possession of a patient safety organization, together with the identity of the reporter and all related correspondence, documentation, analysis, results or recommendations, shall be privileged and confidential and shall not be subject to a civil, criminal, or administrative subpoena or admitted as evidence in any civil, criminal, or administrative proceeding. Nothing herein affects the discoverability or admissibility of facts, information or records referenced as related to patient care from a source other than a patient safety organization.</td>
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<tr>
<td>Washington</td>
<td>Wash. Rev. Stat. § 4.24.250</td>
<td>The proceedings, reports, and written records of peer review committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, are not subject to review or disclosure, or subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a healthcare provider.</td>
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<tr>
<td>West Virginia</td>
<td>W Va. Code §30-3C-3</td>
<td>The proceedings and records of a review organization shall be confidential and privileged and shall not be subject to subpoena or discovery proceedings or be admitted as evidence in any civil action arising out of the matters which are subject to evaluation and review by such organization and no person who was in attendance at a meeting of such organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions or other actions of such organization or any members thereof: Provided, that information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil action merely because they were presented during proceedings of such organization, nor should any person who testifies before such organization or who is a member of such organization be prevented from testifying as to matters within his knowledge, but the witness shall not be asked about his testimony before such an organization or opinions formed by him as a result of said organization hearings: Provided, however, that an individual may execute a valid waiver authorizing the release of the contents of his file pertaining to his own acts or omissions, and such waiver shall remove the confidentiality and privilege of said contents otherwise provided by this section: Provided further, that upon further review by any other review organization, upon judicial review of any finding or determination of a review organization or in any civil action filed by an individual whose activities have been reviewed, any testimony, documents, proceedings, records and other evidence adduced before any such review organization shall be available to such further review organization, the court and the individual whose activities have been reviewed. The court shall enter such protective orders as may be appropriate to provide for the confidentiality of the records provided the court by a review organization and all papers and records relating to the proceedings had before the reviewing court.</td>
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<td>Wisconsin</td>
<td>Wis. Stat § 146.38</td>
<td>All persons, organizations or evaluators, whether from one or more entities, who review or evaluate the services of healthcare providers in order to help improve the quality of healthcare, to avoid improper utilization of the services of healthcare providers, or to determine the reasonable charges for such services shall keep a record of their investigations, inquiries, proceedings and conclusions. No such record may be released to any person under or otherwise except specifically permitted by statute (some instances are listed below). No such record may be used in any civil or criminal action against the healthcare provider or any other healthcare provider, however, except for incident or occurrence reports or records from other persons, organizations, or evaluators reviewing or evaluating healthcare providers, information, documents or records presented during the review or evaluation may not be construed as immune from discovery or use in any civil or criminal action merely because they were so presented. An incident or occurrence report may not be used in any civil or criminal action against a healthcare provider. Information acquired in connection with the review and evaluation of healthcare services shall be disclosed and records of such review and evaluation shall be released, with the identity of any patient whose treatment is reviewed being withheld in the following circumstances: to the healthcare provider whose services are being reviewed or evaluated, upon the request of such provider; to any person with the consent of the healthcare provider whose services are being reviewed or evaluated; to the person requesting the review or evaluation, for use solely for the purpose of improving the quality of healthcare, avoiding the improper utilization of the services of healthcare providers, and determining the reasonable charges for such services; in certain instances, after the issuance of a court-ordered subpoena; and to the appropriate examining or licensing board or agency, when the organization or evaluator conducting the review or evaluation determines that such action is advisable.</td>
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<tr>
<td>Wyoming</td>
<td>WY Stat § 35-17-105</td>
<td>All reports, findings, proceedings and data of the professional standard review organizations is confidential and privileged, and is not subject to discovery or introduction into evidence in any civil action and no person who is in attendance at a meeting of the organization shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the organization or as to any findings, recommendations, evaluations, opinions or other actions of the organization or any members thereof. However, information, documents or other records otherwise available from original sources are not to be construed as immune from discovery or use in any civil action merely because they were presented during proceedings of the organization, nor should any person who testifies before the organization or who is a member of the organization be prevented from testifying as to matters within his knowledge, but that witness cannot be asked about his testimony before the organization or opinions formed by him as a result of proceedings of the organization.</td>
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Neda M. Ryan, Esq. is a Corporate Compliance Attorney for ABC. Ms. Ryan has experience in all areas of healthcare law, including healthcare transactional and corporate matters; healthcare litigation matters; providing counsel regarding compliance and reimbursement matters; and third party payer audit appeals. She can be reached at (517) 787-7432 or at Neda.Ryan@AnesthesiaLLC.com.

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**Advanced Institute for Anesthesia Practice Management**

Securing the Future for Anesthesia Practices
Las Vegas – June 3 - 5, 2016

Eighteen experts in the business of anesthesia and pain medicine will be presenting at this year Advanced Institute for Anesthesia Practice Management (AIAPM) in June. The conference, which is jointly sponsored by Tulane University Health Sciences Center and Medical Business Solutions, LLC, will again take place at The Cosmopolitan in Las Vegas.

Consolidation among of anesthesia and pain medicine practices – acquisitions, mergers and hospital employment – is the single biggest change that continues to confront us all. Leaders of large national anesthesia management companies will talk about maintaining independent hospital relationships and navigating through the acquisition process. There will be presentations on technology, on quality reporting, on the Perioperative Surgical Home, and, in its own track, on coding and billing. Participants will learn about compliance issues in structuring business deals and in acquiring and using technology and social media.

For the conference agenda, registration and hotel information, please contact info@aiapmconference.com.
ANESTHESIA BUSINESS CONSULTANTS

255 W. MICHIGAN AVE.
P.O. BOX 1123
JACKSON, MI 49204

PHONE: (800) 242-1131
FAX: (517) 787-0529
WEB SITE: www.anesthesiallc.com

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TelePREOP is the first and leading provider of telemedicine solutions suited to manage the complex workflows associated with the pre-surgical clinical environments. It is designed to streamline the process between surgeons, hospitals, ASCs and anesthesia.

TelePREOP leverages an industry leader in the technology platform we selected, ePREOP. TelePREOP can engage all Hospital Information Systems that power your healthcare facilities without the overwhelming burden of implementation. The system is already deployed within our environments and allows you to decide to the level of integration thus reducing the time to implementation. Additional information is available on the website at www.TelePREOP.com.

Professional Events

<table>
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<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tr>
<td>June 10-12, 2016</td>
<td>The Florida Society of Anesthesiologists 2016 Annual Meeting and Workshop</td>
<td>The Breakers West Palm Beach, FL</td>
<td><a href="https://www.fsahq.org/meeting/2016-annual-meeting/">https://www.fsahq.org/meeting/2016-annual-meeting/</a></td>
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<tr>
<td>June 24-26, 2016</td>
<td>Annual Perioperative Surgical Home Summit</td>
<td>Hilton Chicago Chicago, IL</td>
<td><a href="http://www.asahq.org/psh/psh%20summit/registration">http://www.asahq.org/psh/psh%20summit/registration</a></td>
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